Retinal Disorders/Ocular Specialty Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________ DOB: __________ Gender: ☐ Male ☐ Female
Address: ______________________City, State, ZIP Code: ______________________
Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: ______________________ Alternate Phone: ______________________
Email: ______________________ Last Four of SSN: __________ Primary Language: __________
Parent/Caregiver/Guardian Name (Last, First): ______________________**Relationship to patient:** __________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________ State License #: ______________________
NPI #: __________ DEA #: __________ Group or Hospital: ______________________
Address: ______________________ City, State, ZIP Code: ______________________
Phone: __________ Fax__________ Contact Person: __________ Contact's Phone: __________

3 INSURANCE INFORMATION
Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______________________ Ship to: ☐ Patient ☐ Office ☐ Other: __________

Diagnosis (ICD-10):

ICD-10 Code: __________ Diagnosis: ______________ Affected eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Patient Clinical Information:

Allergies: ______________________ Height: _______in/cm Weight: ______lb./kg

Durysta: Can only be used once per lifetime per eye.
Has the patient received a prior **Durysta** implant in the treatment eye? ☐ Yes ☐ No

Iluvien:
Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:
Medication prescribed ______________________ Date prescribed ______________________

Susvimo:
Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo:**
Medication prescribed ______________________ Date prescribed ______________________
Medication prescribed ______________________ Date prescribed ______________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Beovu	☐ Vial ☐ PFS	**Induction dose:** ☐ Inject 6 mg monthly for the first three doses ☐ Inject 6 mg every 6 weeks for the first five doses ☐ Other: ______________________ **Maintenance dose:** ☐ Inject 6 mg every 8 to 12 weeks ☐ Other: ______________________	Quantity: __________ Refills: __________
☐ Byooviz	☐ 0.5 mg single-dose vial	☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: ______________________	Quantity: ________ Refills: ________
☐ Other: __________	☐ Strength: __________	☐ Dose: ______________________	Quantity: __________ Refills: __________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ______________**Date:** ______	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ______________**Date:** ______

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" __________ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Please Complete Patient and Prescriber Information

Patient Name: ________________________ Patient DOB: ____________ Patient Phone: ____________
Prescriber Name: ________________________ Prescriber Phone: ________________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cimerli	☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Durysta	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______
☐ Eylea	☐ Vial ☐ PFS	☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) ☐ Pediatric - Inject 0.4mg (0.01mL) ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Eylea HD	☐ 8mg	☐ Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by 8 mg every 8 to 16 weeks (2 to 4 months) ☐ Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by every 8 to 12 weeks (2 to 3 months) ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Iluvien	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______
☐ Izervay	☐ 2 mg single-dose vial (0.1 mL of 20 mg/mL solution)	☐ Prepare and administer 2 mg by intravitreal injection into each affected eye once monthly (approximately 28 days) ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Lucentis	☐ 0.3 mg/0.05 mL single-dose PFS ☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose PFS ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Ozurdex	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Retisert	☐ 1 implant	☐ To be implanted by physician as directed ☐ Other: ____________	Quantity: ______
☐ Susvimo Refill Kit	☐ 1 Refill Kit	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Vabysmo	☐ 6 mg	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Visudyne	☐ Vial	☐ To be infused by physician as directed ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Xdemvy	☐ 0.25%	☐ Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Yutiq	☐ 0.18 mg (single dose implant)	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Other: ________	☐ Strength: ____________	☐ Dose: ____________	Quantity: ______ Refills: ______

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